COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

GIFT CARD AUTHORIZATION

DATE _____

_____
Mental Health Clinic

_____ _____
Authorized Name (Mental Health Professional) Payroll Title

Issue _____ Gift Cards for vendor(s) _____
Number of Cards

In the amount of $_____ to _____
Client Name

Client address: _____ _____
Street City Client Social Security No. or IS No.

To be used for _____
(Brief Explanation)

_____
Authorized Signature
(Mental Health Professional/Case Manager)

ACKNOWLEDGEMENT

I acknowledge receipt of _____ Gift Card
(number)

_____
Signature of Client Date

Signature of Designated Custodian (or designee) issuing gift cards _____